

# PATIENT INFORMATION

(patient signature) \_\_\_\_\_

(date) \_\_\_\_\_

(This information is necessary for our files and will be considered **CONFIDENTIAL**)

**Patients Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Spouse's Name** \_\_\_\_\_

LAST FIRST INITIAL

**If patient is a minor, give parent's or guardian's name:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Residence Address** \_\_\_\_\_ **CITY** \_\_\_\_\_ **ZIP** \_\_\_\_\_

STREET

Married  Single  Divorced  Separated  Widowed

**Cell Phone No.** \_\_\_\_\_ **Soc. Sec. No.** \_\_\_\_\_ **Res. Phone** \_\_\_\_\_

**E-mail** \_\_\_\_\_ **Patient's Birthdate** \_\_\_\_\_

**Employed by** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Business Address** \_\_\_\_\_ **Bus. Phone** \_\_\_\_\_

**Spouse Employed by** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Business Address** \_\_\_\_\_ **Bus. Phone** \_\_\_\_\_

**Name of nearest relative not living with you:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Complete Address** \_\_\_\_\_ **Res. Phone** \_\_\_\_\_

**Name of Physician** \_\_\_\_\_ **Addr** \_\_\_\_\_

STREET

CITY

TELEPHONE

**Date of last visit** \_\_\_\_\_

**Former Dentist** \_\_\_\_\_ **Addr** \_\_\_\_\_

STREET

CITY

TELEPHONE

**Date of last visit** \_\_\_\_\_ **Date of your last dental xrays** \_\_\_\_\_

**Purpose of today's appointment** \_\_\_\_\_

**Whom may we thank for referring you?** \_\_\_\_\_

## FINANCIAL and INSURANCE INFORMATION

### PERSON RESPONSIBLE FOR THIS ACCOUNT:

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Dental Insurance** \_\_\_\_\_ (Name of Co.)

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Insurance Group No.** \_\_\_\_\_

**Cash on day of treatment**

**Employer** \_\_\_\_\_

**VISA**  **American Express**  **Discover**  **Mastercard**

**Name of Insured** \_\_\_\_\_

**Card No.** \_\_\_\_\_

**Soc. Sec. No. of Insured** \_\_\_\_\_

## TERMS & CONDITIONS

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms to assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of the patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES!**

**HEALTH HISTORY** Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:		_____	
		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Due Date _____			
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

**Do you need to premedicate before dental work?**  Yes  No

List medications you are currently taking:	Alcohol Use	Tobacco Use	Allergies Food/Medication
	<input type="checkbox"/> No Use	<input type="checkbox"/> No Use	
	<input type="checkbox"/> Past History	<input type="checkbox"/> Cigarettes # Years # per Day _____	
	<input type="checkbox"/> Less than 8 drinks per week	<input type="checkbox"/> Cigars	
	<input type="checkbox"/> 8-21 drinks per week	<input type="checkbox"/> Pipes	
	<input type="checkbox"/> More than 21 drinks per week	<input type="checkbox"/> Chewing Tobacco	
		<input type="checkbox"/> Past History	

Have you ever taken Fen-Phen?  Yes  No  
If yes, have you had an echocardiogram?  Yes  No

Are you presently taking Coumadin or any blood thinner?  Yes  No

DATE	PATIENT'S/PARENT'S SIGNATURE	P/BP	DOCTOR'S SIGNATURE

**UPDATES** (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment?  Yes  No

For what conditions? \_\_\_\_\_

Are you taking any new medications? \_\_\_\_\_ If so, what \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date: \_\_\_\_\_